County of Los Angeles
Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Screening and Mandating Reporting of Intimate Partner Violence for Physicians

Intimate partner violence (IPV) is a serious yet preventable public health problem in the United States, affecting approximately 4.8 million females and 2.9 million males annually. Due to the extent and associated morbidity of IPV national health care organizations recommend providers screen their patients for intimate partner violence as part of their routine examination.

The physician examination room setting offers a safe and appropriate environment for IPV screening and referral. However even with numerous published recommendations for routine screening of IPV by physicians, most women who have been abused have not been identified in the medical system. This low rate of physician-patient communication about IPV is due to the lack of direct questioning of IPV by physicians. Without a physician asking about abuse, an abused woman will generally not self-disclose the abuse by herself. While studies suggest that most female patients support direct questioning of IPV by their physicians, a statewide study of primary care physicians in California showed that only 10% screened their patients for IPV during routine examinations.

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Los Angeles Mommy and Baby (LAMB) Project Expanded to Cover Entire County

The Los Angeles Mommy and Baby (LAMB) survey, developed to identify risk factors associated with poor birth outcomes in response to the rising infant mortality rate in the Antelope Valley, has been so successful that it will be expanded to cover all of Los Angeles County. This expansion will provide the maternal data that has been lacking at the local level, which will inform community-based planning efforts as well as research on birth outcomes.

Background

In response to a rise in infant mortality in the Antelope Valley that occurred between 1998 and 2002, the Department of Health Services (DHS) convened a working group consisting of various programs within DHS, Antelope Valley community organizations, and health care organizations to develop recommendations and actions to improve birth outcomes. A key recommendation was to conduct further research to identify the causes of this increase in the Antelope Valley. (This problem and the working group's recommendations were highlighted in the October 2004 issue of the Public's Health www.lapublichealth.org/wwwfiles/ph/ph/ph/TPH_October_2004.pdf).

DHS' Maternal, Child, and Adolescent Health (MCAH) Programs initiated two major research projects in response to this recommendation:

- **A thorough infant mortality review of the Antelope Valley infant deaths that occurred in 2002.** The purpose of this project was to identify risk factors associated with the increase in infant mortality. This was a joint effort among the DHS Public Health Nurses in SPA 1 and the medical experts and concerned community members. Public Health Nurses reviewed medical charts and interviewed mothers who lost their infants. In early April 2005, the Antelope Valley Community Action Team will review the findings, which are currently being compiled, and identify potential prevention and intervention strategies.

- **Piloting the Los Angeles Mommy and Baby (LAMB) Survey in Antelope Valley.** The purpose of the project was to identify risk factors such as maternal stress, pre-existing medical conditions, quality of prenatal care and other factors associated with poor birth outcomes such as low birth weight and preterm delivery. Low birth weight and prematurity have been known as the leading causes of infant deaths. Surveys were mailed out between October 2004 and February 2005 in Antelope Valley to a randomly selected sample of approximately 950 mothers who recently delivered. Every effort has been made to achieve a high response rate, such as offering incentives, allowing surveys to be completed

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over the phone if the respondent prefers not to mail it, promoting the survey at community health fairs, and working with medical providers to promote the survey. These efforts have paid off, as the response rate has been much higher than for most surveys, and MCAH continues to receive completed surveys and requests to complete the survey by phone.

Preliminary findings from these two projects will be available for public access in the Spring, 2005 (please visit http://lapublichealth.org/mch/rep/rep.htm).

LAMB expansion

Due to support received by community partners to promote the LAMB Project as well as a high response rate from clients surveyed, the LAMB Project will now be expanded to cover the entire county. There is currently no source of maternal surveillance data that can be analyzed at the local level. In a county as large and diverse as Los Angeles, the inability to analyze data at the sub-county level leaves a hole in our understanding of the problems and needs of our population. The LAMB expansion will address the lack of information on the perinatal population and allow county and community members to focus their resources and develop strategies based on evidence, providing county and SPA-level data on maternal health prior, during or after pregnancy. The LAMB expansion will also improve data collection on currently unavailable areas such as preconception and interconception care, social support, client awareness of standard medical services during pregnancy, domestic violence and risk factors for birth outcomes Another key LAMB objective is to improve data dissemination of survey results to stakeholders providing services to the same study population.

> ***"The purpose of the LAMB Project was to identify risk factors such as maternal stress, pre-existing medical conditions, quality of prenatal care and other factors associated with poor birth outcomes such as low birth weight and preterm delivery"***

The LAMB expansion has an added benefit for women – a resource directory on health and social service resources for families in their geographic area is included with the survey mailed to women. Some of the mothers surveyed in Antelope Valley have requested additional referral information, which MCAH provided, and shared their appreciation for the County's efforts to better understand their challenges during pregnancy in the hopes that their experience can help other pregnant women.

> "I just wanted to comment that I am very happy that we're being taken into account. Thank you for caring about the people especially the women because it is another option for those who do not dare to communicate their family problems such as domestic violence. I hope that with this survey they feel at liberty to communicate if they have some of these problems"
>
> LAMB Respondent

How providers can help with the expansion effort

Providers played a key role in the success of the survey in the Antelope Valley, and the MCAH program would like to thank the providers who discussed the LAMB survey with their clients in the Antelope Valley. As we learned from the Antelope Valley pilot, the success of the countywide LAMB Survey is contingent upon a collaborative effort involving DHS, community partners, respondents and medical providers like you.

Close to 10,000 women across the county who delivered a baby in the calendar year 2005 will receive a LAMB survey in the mail starting in June 2005. We are asking all health care providers to encourage their patients who receive them to complete and return the surveys promptly.

*Reporting of Intimate Partner Violence for Physicians.....*from page 1

Evidence & Recommendations for Screening

The U.S. Preventive Services Task Force found "insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, or women for intimate partner violence, or older adults or their caregivers for elder abuse". While false-positive tests could compromise the physician-patient relationship and screening could increase psychological stress and further abuse these have not been adequately studied. However, by leaving IPV undiagnosed, the victim is at risk for continued abuse, re-victimization, homicide, suicide, brain injury, physical injury, and chronic health conditions. The American Medical Association , American Academy of Pediatrics , American College of Obstetricians and Gynecologists , American Academy of Family Physicians , and the American College of Emergency Physicians recommend asking routine direct questions about IPV.

The effectiveness of IPV screening can be further illustrated through Prochaska and DiClemente's Transtheoretical Stages of Change Model, an approach that identifies the stage of readiness for a patient to make a behavioral change. During precontemplation stage, a victim does not recognize they are in an abusive relationship. However when a physician presents screening questions, this increases awareness of the victim and results in a thought process resulting in an association between abuse and their health condition. During contemplation, the victim begins to accept that their relationship is abusive and begins to understand the advantages and disadvantages of change in the relationship. This is where the physician is most effective in providing IPV support, information and referral.

Common Signs and Symptoms of IPV Victimization

While the signs and symptoms of IPV may be difficult to observe, the following are common characteristics associated with IPV victimization.

- Patient's predisposing factors to IPV: Include depression, suicide attempts, drug overdose, alcohol abuse, delay in seeking medical care, repeated emergency visits, vague, non-specific symptoms such as headaches, gastrointestinal, history inconsistent with injury, and traumatic injury or sexual assault.
- Physical Indicators: Unexplained, multiple injuries, or injuries at various stages of healing. IPV can escalate during pregnancy, spontaneous abortion, premature labor, miscarriage.
- Behavioral Indicators: Overly protective or controlling partner who is not willing to leave the patient alone; reluctant to speak in front of partner; panic attacks, defensiveness, anger, anxiety, flat affect behavior.

Barriers to Screening

Barriers to disclose IPV can include those from both the patient and physician. Often patients are hesitant to disclose IPV due to threats from the perpetrator to hurt or take away their children or threaten to harm the victim, if he or she discloses abusive information. The victim may also feel they are to blame for the abuse. Cultural backgrounds also play an important role in whether a victim feels safe or that it is appropriate to disclose abuse. Barriers among physicians can include lack of time during examination and fear of opening a complicated social and psychological discussion. In addition, physicians themselves may feel hesitant to screen due to their own fear of opening traumatic memories of their own abusive relationships.

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Clinical presentations associated with victimization:

1. Depression, sleep disorders, panic attacks, anxiety
2. Self-neglect, dehydration, failure-to-thrive, malnutrition
3. Alcohol, drug abuse
4. Poor adherence to medical recommendations
5. Repeated self-injury, dissociative states
6. Aggression towards self and others
7. Suicide attempts
8. Stealing, lying, truancy, children running away
9. Somatizing disordes, chronic pain, eating disorders
10. Compulsive sexual behaviors, sexual dysfunction

Common life event symptom triggers for survivors of childhood abuse:

1. Pregnancy or birth of a child
2. Illness or death of a parent/perpetrator
3. Divorce of parents
4. Age of patient's child recall of onset of abuse
5. Key "anniversary" dates or holidays
6. Family get-togethers or reunions
7. Illness or injury of child
8. Hospitalization
9. Workplace situations that mirror a relationship with abuser
10. Home re-location, especially to area where abuse occurred
11. Viewing movies or television shows that have abusive content

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How to Screen

To effectively screen for IPV the physician must first establish a good rapport with the patient and provide a safe private setting. Various screening tools have been evaluated and shown to be effective. These include the Conflict Tactics Scale (CTS), Abuse Assessment Screen (AAS), Index of Spouse Abuse (ISA), Danger Assessment Screen (DAS), and the Partner Violence Screen (PVS). Based on a systematic evidence-based review for the U.S. Preventive Services Task Force, the Partner Violence Screen (PVS) is most applicable to health care providers. The PVS questions include the following three questions:

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the last year?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

When screening results are positive, the physician must first present a clear message to the patient that, you believe the patient, it is not their fault, the patient is not alone, and that help is available. Secondly ask if it is safe for the patient to go home. If yes, does she have a safety plan for getting out of the home along with children, if any? If it is not safe to go home, ask if the patient can stay with family or friends or arrange for a shelter?

Be sure the patient receives a list of shelters, resources and hotline numbers. The patient can contact the National Domestic Violence Hotline at (800) 799-7233 for assistance with developing a safety plan. If there are children in the home, are they in danger? If yes, it is necessary to file a suspected Child Abuse Report.

Recommended IPV Screening Tool: Partner Violence Screen (PVS):

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the last year?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Mandated Reporting by Physicians

California Penal Code Section 11160 mandates that a physician call the local law enforcement agency by telephone immediately or as quickly as possible. The physician should be familiar with their own hospital, clinic, or HMO policies and procedures regarding the use of specific reporting forms. These forms must be completed and mailed to a law enforcement agency within 48-hours. The physician is recommended to document all injuries of the victim by using a body map or photographs if possible. When writing the report, use patient's own words regarding injury and abuse.

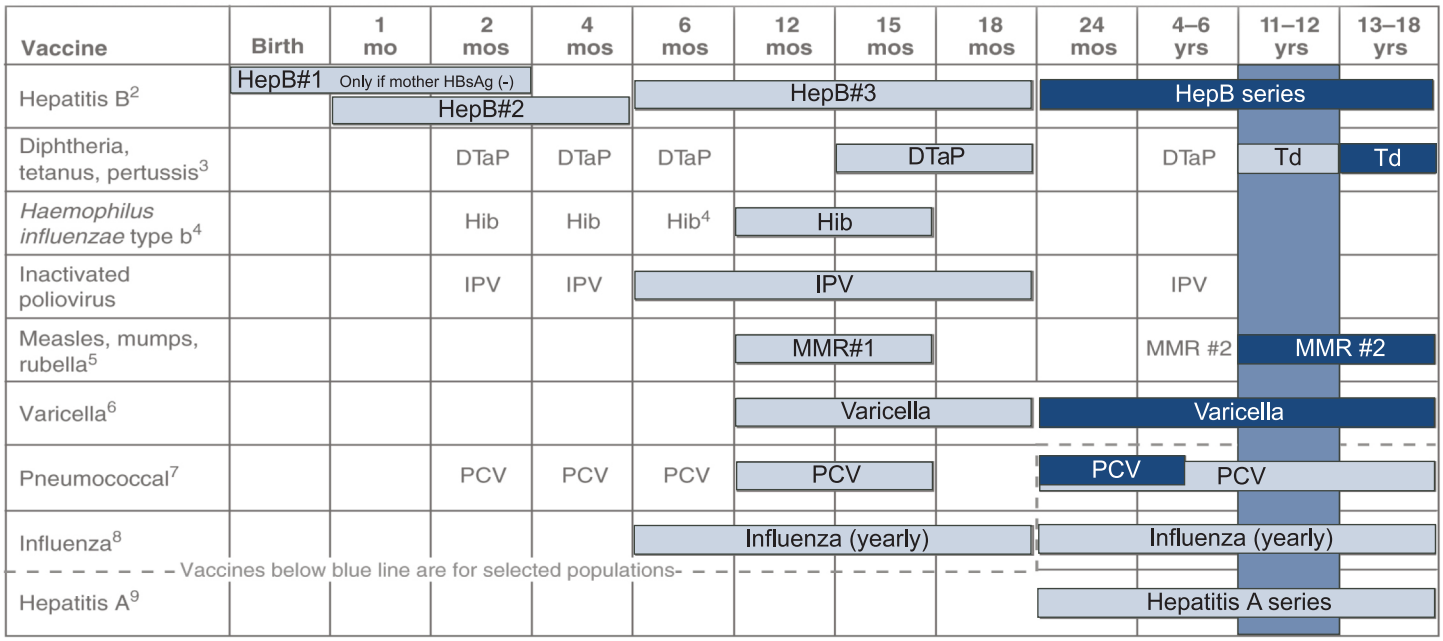
CME CREDIT. An abused woman will often hesitate to report intimate violence, unless asked directly. Women exposed to violence make more visits to hospitals and clinics than women who have not. In an effort to educate providers about IPV the AMA has designated an educational activity for a maximum of one hour in Category 1 credit toward the AMA Physician's Recognition Award. Order by phone at (800) 621-8335 or by FAX at (312) 464-5600 and refer to product order #OP426102 [http://www.ama-assn.org/ama/pub/category/9212.html].

RECOMMENDED CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE UNITED STATES, 2005

CDC's Advisory Committee on Immunization Practices (ACIP) published the Recommended Childhood and Adolescent Immunization Schedule -- United States, 2005 in the January 7, 2005 issue of the MMWR Quick Guide (Vol. 53 / Nos. 51 & 52)*. There are no changes in the new schedule from the July – December 2004 schedule. In addition, the catch-up immunization schedule for children and adolescents who start late or who are over 1 month behind has not changed from that published in January 2004 and again in April 2004. American Academy of Pediatricians (AAP) and American Academy of Family Physicians (AAFP) approve the new ACIP 2005 Recommended Childhood and Adolescent Immunization Schedule.

* www.cdc.gov/mmwr/pdf/wk/mm5351-Immunization.pdf

Recommended Childhood and Adolescent Immunization Schedule United States 2005



1. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children aged ≤18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ▬ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines might be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated. Providers should consult package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System; guidance is available at http://www.vaers.org or by telephone, 800-822-7967.

2. Hepatitis B (HepB) vaccine. All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be administered by age 2 months if the mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB may be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is administered. The second dose should be administered at least 4 weeks after the first dose, except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks. ***Infants born to HBsAg-positive mothers*** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) at separate sites within 12 hours of birth. The second dose is recommended at age 1–2 months. The final dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg at age 9–15 months. ***Infants born to mothers whose HBsAg status is unknown*** should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be administered at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4, or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

5. Measles, mumps, and rubella (MMR) vaccine. The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

6. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

7. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be administered at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain groups at high risk. See *MMWR* 2000;49(No. RR-9).

8. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], and diabetes), health-care workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[No. RR-6]). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(No. RR-6). Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain groups at high risk; consult your local public health authority. Children and adolescents in these states, regions, and groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(No. RR-12).

Approved by the **Advisory Committee on Immunization Practices** (http://www.cdc.gov/nip/acip), the **American Academy of Pediatrics** (http://www.aap.org), and the **American Academy of Family Physicians** (http://www.aafp.org). Additional information about vaccines, including precautions and contraindications for vaccination and vaccine shortages, is available at http://www.cdc.gov/nip or from the National Immunization Information Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish).

Catch-Up Immunization Schedules

for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

The tables give catch-up schedules and minimum intervals between doses for children and adolescents who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses.

Catch-up schedule for children aged 4 months–6 years

Vaccine	Minimum age for dose 1	Minimum interval between doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
DTaP[1]	6 wks	4 wks	4 wks	6 mos	6 mos[1]
IPV[2]	6 wks	4 wks	4 wks	4 wks[2]	
HepB[3]	Birth	4 wks	8 wks (and 16 wks after first dose)		
MMR[4]	12 mos	4 wks[4]			
Varicella	12 mos				
Hib[5]	6 wks	4 wks: if first dose administered at age <12 mos 8 wks (as final dose): if first dose administered at age 12–14 mos No further doses needed if first dose administered at age ≥15 mos	4 wks[6]: if current age <12 mos 8 wks (as final dose)[6]: if current age ≥12 mos and second dose administered at age <15 mos No further doses needed if previous dose administered at age ≥15 mos	8 wks (as final dose): This dose only necessary for children aged 12 mos–5 yrs who received 3 doses before age 12 mos	
PCV[7]	6 wks	4 wks: if first dose administered at age <12 mos and current age <24 mos 8 wks (as final dose): if first dose administered at age ≥12 mos or current age 24–59 mos No further doses needed for healthy children if first dose administered at age ≥24 mos	4 wks: if current age <12 mos 8 wks (as final dose): if current age ≥12 mos No further doses needed for healthy children if previous dose administered at age ≥24 mos	8 wks (as final dose): This dose only necessary for children aged 12 mos–5 yrs who received 3 doses before age 12 mos	

Catch-up schedule for children aged 7–18 years

Vaccine	Minimum interval between doses		
	Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to booster dose
Td[8]		6 mos	6 mos[8]: if first dose administered at age <12 mos and current age <11 yrs 5 yrs[8]: if first dose administered at age ≥12 mos and third dose administered at age <7 yrs and current age ≥11 yrs 10 yrs[8]: if third dose administered at age ≥7 yrs
IPV[9]		4 wks	IPV[2,9]
HepB		8 wks (and 16 wks after first dose)	
MMR			
Varicella[10]			

Note: A vaccine series does not require restarting, regardless of the time that has elapsed between doses.

1. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.

2. Inactivated poliovirus (IPV) vaccine. For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

3. Hepatitis B (HepB) vaccine. All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.

4. Measles, mumps, and rubella (MMR) vaccine. The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.

5. *Haemophilus influenzae* type b (Hib) vaccine. Vaccine is not generally recommended for children aged ≥5 years.

6. Hib vaccine. If current age is <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.

7. Pneumococcal conjugate (PCV) vaccine. Vaccine is not generally recommended for children aged ≥5 years.

8. Tetanus and diphtheria toxoids (Td). For children aged 7–10 years, the interval between the third and booster dose is determined by the age when the first dose was administered. For adolescents aged 11–18 years, the interval is determined by the age when the third dose was administered.

9. IPV. Vaccine is not generally recommended for persons aged ≥18 years.

10. Varicella vaccine. Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.org or call the 24-hour national toll-free info line 1-800-822-7967. Report suspect cases of vaccine-preventable diseases to your state or local health department.

THE GONOCOCCAL ISOLATE SURVEILLANCE PROJECT: 2003-2004

BACKGROUND

The Gonococcal Isolate Surveillance Project is a collaborative undertaking between STD clinics at 30 sentinel sites, five regional laboratories, and the CDC to investigate the increase in fluoroquinolone resistance in males, particularly men who have sex with men (MSM). Los Angeles County became a sentinel site in 2003, with two clinics chosen to submit isolates. One site is an STD clinic, the other is a community-based organization which serves MSM.

Humans are the natural reservoir for Neisseria gonorrhoeae, the bacteria that causes gonorrhea. Gonorrhea (GC) is typically an uncomplicated infection of the lower genital tract. However, untreated infections can lead to pelvic inflammatory disease in females and epididymitis in males. Disseminated disease affecting multiple organ systems may also result. Individuals with gonorrhea are more likely to acquire HIV infection, demonstrating the need for HIV screening for those infected with GC.

METHODS

In March 2003, the two clinics in Los Angeles participating in the study began collecting urethral cultures from symptomatic males. These clinics also collect demographic, clinical, and client-reported behavioral data. Cultures from symptomatic men are sent to the Los Angeles County Public Health Laboratory for testing, and positive GC isolates presumptively identified by the lab are shipped to the Denver GISP Regional Laboratory for confirmation and antibiotic susceptibility testing. Antibiotic resistance information is forwarded to CDC and the county health department's STD Program.

RESULTS

395 total isolates were obtained (270 from STD clinic, 125 from community-based organization).

53 participants with ciprofloxacin-resistant isolates were identified from March 2003 through August 2004:

- 40% of ciprofloxacin-resistant isolates from STD clinic, 60% from community-based organization.
- Mean age was 34 years.
- 49% African American; 32% White
- 21 heterosexual; 28 gay; 4 bisexual
- 5 HIV positive
- 6 with unknown HIV status; 25 partners with unknown HIV status

RECOMMENDATIONS

- Uncomplicated gonococcal infections of the cervix, urethra, and rectum should be treated with ceftriaxone 125 mg intramuscularly or cefixime 400 mg orally. Although fluoroquinolones (including ciprofloxacin, ofloxacin, and levofloxacin) are no longer recommended for the treatment of GC in California, 146 (1.2%) of GC cases reported to LAC STDP were treated with fluoroquinolones from March 2003 through October 2004.
- Alternate treatment is spectinomycin 2 g intramuscularly or ceftizoxime 500 mg intramuscularly, cefoxitin 2 g intramuscularly with probenecid 1 g orally, cefotaxime 500 mg intramuscularly, or cefpodoxime 400 mg po x 1
- Gonococcal infections of the pharynx should be treated with ceftriaxone 125 mg intramuscularly.
- Spectinomycin 2 g intramuscularly can be used as an alternative in patients with penicillin or cephalosporin allergies.
- Co-treatment of chlamydia in patients with gonorrhea is still recommended unless chlamydia infection has been ruled out. The recommended co-treatment is azithromycin 1 g orally or doxycycline 100 mg orally, twice a day for seven days.

Further information on antibiotic resistance and gonorrhea treatment guidelines can be found at:

www.lapublichealth.org/std/2003_CA_GC_Rx_guides.pdf.

DHS's 1st Veterinary Public Health Extern

Joyce Lee, a fourth year veterinary student at Wisconsin's School of Veterinary Medicine, is DHS's first veterinary public health extern. The State of California and the CDC provide limited public health training, but it has not existed at the local level.

The program offers an opportunity for veterinary students to explore a potential career in public health while providing "hands on" experience working in a metropolitan health department which handles a variety of problems.

The 21st century has seen increased societal concern related to public health. The CDC has categorized the diseases most likely to be used by terrorists and the majority are animal diseases transmissible to people. These disease agents require health agencies have expertise in veterinary medicine. "Mad Cow" disease, a fatal neurological disease of animals, was recently found to be transmitted in the food chain to people. Millions of dollars have been spent trying to control the disease and nations have placed embargos in attempts to avoid it.

Veterinary students interested in the program can find more information at http://lapublichealth.org/vet/externship/main.htm. The nation's newest school of veterinary medicine is at Western University in Pomona, which is located in Los Angeles County. Western plans to have some of their students rotate through DHS's program. Success will require a dynamic partnership between DHS and the academic community.

Calendar

Pertussis: Something Old ~ Something New

Since the 1980's, the incidence of pertussis has increased nationally and in Los Angeles County. Often, this disease goes undiagnosed, especially in adolescents and adults. This symposium will cover significant aspects of pertussis including: clinical presentation, laboratory diagnosis, changing epidemiology, impact on public health, new adolescent and adult vaccines. This program is applicable for MDs, RNs, LVNs, CNMs, NPs, and PAs. Other health care professionals, laboratory personnel, and health care students may also attend. Approved for 3.5 hours of CME credits. For more information, contact the Immunization Program at 213-351-7800.

Space is limited. Registration form is available at www.lapublichealth.org/ip/ ; deadline for registration is May 2nd.

Date: Wed, May 18, 2005
Time: 8:30 am - 1:00 pm
Place: Sheraton Cerritos Hotel Towne Center
12725 Center Court Dr. Cerritos, CA 90703

This Issue . . .

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

Selected Reportable Diseases (Cases)* - November 2004

Disease	THIS PERIOD Nov. 2004	SAME PERIOD LAST YEAR Nov. 2003	YEAR to date Nov. 2004	YEAR to date Nov. 2003	YEAR END TOTALS 2003	2002	2001
AIDS*	150	247	2,216	2,298	2,590	1,719	1,354
Amebiasis	3	9	88	118	121	102	139
Campylobacteriosis	71	68	859	1,032	1,093	1,067	1,141
Chlamydial Infections	3,323	3,383	32,113	31,117	36,555	35,688	32,670
Encephalitis	28	2	125	39	41	61	41
Gonorrhea	872	741	7,971	6,697	8,008	7,800	7,743
Hepatitis Type A	19	49	297	359	376	438	542
Hepatitis Type B, Acute	3	9	63	66	56	29	44
Hepatitis Type C, Acute	0	0	5	0	0	3	1
Measles	0	0	1	0	0	0	8
Meningitis, viral/aseptic	62	95	749	1,059	899	466	530
Meningococcal Infections	3	1	29	28	34	46	58
Mumps	0	0	2	10	10	16	17
Non-gonococcal Urethritis (NGU)	101	129	1,232	1,202	1,393	1,393	1,429
Pertussis	15	0	101	97	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	110	79	1,087	949	996	956	1,006
Shigellosis	90	84	518	740	671	974	684
Syphilis, primary & secondary	40	33	373	375	442	364	188
Syphilis, early latent (<1 yr.)	27	33	328	310	365	353	209
Tuberculosis	89	87	714	740	949	1,021	1,046
Typhoid fever, Acute	0	1	13	15	16	33	17

* Case totals are provisional and may vary following periodic updates of the database.